



ANTICONVULSANTS PA SUMMARY

PREFERRED	Banzel tablets, Carbatrol capsules (brand), Depakote DR tablets (brand), Depakote Sprinkles (brand), Diastat AcuDial rectal gel (brand), Diastat Pediatric rectal gel (brand), Divalproex ER tablets (generic), Felbatol (brand), Gabapentin capsules, Lamotrigine tablets and chewable dispersible tablets, Levetiracetam tablets and solution, Lyrica capsules, Onfi, Oxcarbazepine (generic), Topamax sprinkle capsules, Topiramate tablets, Valproic Acid syrup (generic Depakene syrup), Vimpat (oral solution, tablets, injectable), Zonisamide
NON-PREFERRED	Banzel suspension, Carbamazepine SR capsules (generic), Depakote ER tablets (brand, Edit 22), Diazepam rectal gel (generic), Divalproex DR tablets (generic), Divalproex sodium oral capsule gastro-resistant sprinkles (generic), Felbamate (generic), Fycompa, Gabapentin solution and tablets (generic), Gabitril, Lamictal Kits, Lamictal ODT, Lamictal XR, Lamotrigine kit, Levetiracetam extended-release tablets, Lyrica oral solution, Oxtellar XR, Potiga, Sabril tablets and powder for solution, Stavzor, Tiagabine (generic), Valproic Acid capsules (generic Depakene capsules)

LENGTH OF AUTHORIZATION: Varies

NOTE: Criteria for Horizant are listed in a separate document. If Keppra XR is approved, the PA will be issued for the generic product, levetiracetam extended-release tablets. Brand Diastat only requires PA for members age 21 and over; generic diazepam rectal gel requires PA for members of all ages. If generic diazepam rectal gel is approved, the PA will be issued for brand Diastat rectal gel. If generic tiagabine is approved, the PA will be issued for brand Gabitril. If generic lamotrigine ER is approved, the PA will be issued for brand Lamictal XR.

PA CRITERIA:

For Banzel

- ❖ Approvable for members 4 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) when used in combination with other anticonvulsant(s).

AND

- ❖ Member must have experienced an insufficient response to at least two medications used for LGS.
- ❖ For Banzel suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by the tablets.

For Carbamazepine SR (generic)

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand-name Carbatrol, is not appropriate for the member.



For Diastat/Diazepam Rectal gel

- ❖ Approvable for members with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen.

AND

- ❖ Must be used for increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity. Brand Diastat is preferred; if the generic is requested, the physician should submit a written letter of medical necessity stating the reason(s) that brand-name Diastat is not appropriate.

For Divalproex (generic Depakote)

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, the same formulation of brand-name Depakote, is not appropriate for the member.

For Felbamate (generic)

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand-name Felbatol, is not appropriate for the member.

For Gabapentin solution or tablets

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, gabapentin capsules, is not appropriate for the member. Otherwise, gabapentin solution is approvable for members unable to swallow solid dosage forms (or members who are less than 13) who have tried two other anticonvulsants available in liquid formulations.

For Fycompa or Gabitril (brand or generic tiagabine)

- ❖ Approvable as an adjunct anticonvulsant for members 12 years or older who have tried and failed at least two other anticonvulsants.

For Levetiracetam XR

- ❖ Physician should submit a written letter of medical necessity stating the reason(s) the preferred product, generic immediate-release levetiracetam tablets or solution, is not appropriate for the member.

For Lamictal ODT or XR (brand or generic lamotrigine ER)

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member. Exceptions include requests for Lamictal ODT in members with bipolar disorder unable to swallow solid dosage forms or members or in members with epilepsy unable to swallow who have tried and failed at least two other anticonvulsants.

For Lamictal Kits

- ❖ Physician must submit a written letter of medical necessity stating the reasons the non-kit formulation is not appropriate for the member.

For Lyrica oral solution

- ❖ Member must be unable to swallow capsules.

For Onfi

- ❖ Approvable for members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an insufficient



response to clonazepam and at least one other anticonvulsant used for LGS. Must be used in combination with other anticonvulsant(s).

AND

- ❖ Member must have experienced an insufficient response to another medication used for LGS.

For Oxtellar XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic oxcarbazepine, is not appropriate for the member.

For Potiga

- ❖ Approvable as an adjunct anticonvulsant for members 18 years of age or older who have tried and failed at least two other anticonvulsants

AND

- ❖ Prescriber and member must be aware of the risks of eye abnormalities characterized by pigment changes in the retina and the need for periodic eye exams

AND

- ❖ Member must see an ophthalmologist for a baseline visual assessment.

For Sabril

- ❖ Approvable for members 1 month-2 years with infantile spasms
- ❖ Approvable as an adjunct anticonvulsant for members 16 years of age and older with refractory complex partial seizures who have tried and failed at least two other anticonvulsant medications
- ❖ Prescriber and member must be enrolled in the Sabril SHARE program.

AND

- ❖ Prescriber and member must be aware of the risks of permanent vision loss/reduced visual acuity and the need for visual monitoring during therapy and for up to 6 months after therapy discontinuation.

AND

- ❖ Member must see an ophthalmologist for a baseline visual assessment.

For Stavzor and Valproic Acid Capsules

- ❖ Approvable for discharge prescriptions if started in hospital

OR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Depakote DR, Depakote sprinkles, divalproex ER, or valproic acid syrup, are not appropriate for the member.

For Vimpat (oral solution, tablets, and injection)

- ❖ Approvable for members 17 years of age or older with seizures/epilepsy when used in combination with other anticonvulsant(s).

AND

- ❖ Vimpat injection requires faxed documentation of clinical benefit from Vimpat tablets and temporary inability to swallow or absorb the tablets. Vimpat injection must be administered in member's home by home health or in a long-term care facility.

EXCEPTIONS:



- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827**.

PA and Appeal Process:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

Quantity Level Limitations:

- ❖ For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.